

CALIFORNIA CODES
WELFARE AND INSTITUTIONS CODE
SECTION 14124.70-14124.94

14124.70. As used in this article:

(a) "Carrier" includes any insurer as defined in Section 23 of the Insurance Code, including any private company, corporation, mutual association, trust fund, reciprocal or interinsurance exchange authorized under the laws of this state to insure persons against liability or injuries caused to another, and also any insurer providing benefits under a policy of bodily injury liability insurance covering liability arising out of the ownership, maintenance or use of a motor vehicle which provides uninsured motorist endorsement or coverage, pursuant to Section 11580.2 of the Insurance Code.

(b) "Beneficiary" means any person who has received benefits or will be provided benefits under this chapter because of an injury for which another person or party may be liable. It includes such beneficiary's guardian, conservator or other personal representative, his estate or survivors.

(c) "Reasonable value of benefits" means both of the following:

(1) Except in a case in which services were provided to a beneficiary under a managed care arrangement or contract, "reasonable value of benefits" means the Medi-Cal rate of payment, for the type of services rendered, under the schedule of maximum allowances authorized by Section 14106 or, the Medi-Cal rate of payment, for the type of services rendered, under regulations adopted pursuant to this chapter, including but not limited, to Section 14105.

(2) If services were provided to a beneficiary under a managed care arrangement or contract, "reasonable value of benefits" means the rate of payment to the provider by the plan for the services rendered to the beneficiary, except in cases where the plan pays the provider on a capitated or risk sharing basis, in which case it means the value of the services rendered to the beneficiary calculated by the plan as the usual customary and reasonable charge made to the general public by the provider for similar services.

14124.71. (a) When benefits are provided or will be provided to a beneficiary under this chapter because of an injury for which another person is liable, or for which a carrier is liable in accordance with the provisions of any policy of insurance issued pursuant to Insurance Code Section 11580.2, the director shall have a right to recover from such person or carrier the reasonable value of benefits so provided. The Attorney General, or counsel for the fiscal intermediary under the Medi-Cal program with the permission of the Attorney General, or a contractor pursuant to Section 14124.80, or a county through its civil legal adviser, may, to enforce such right, institute and prosecute legal proceedings against the third person or carrier who may be liable for the injury in an appropriate court, either in the name of the director or in the name of the injured person, his guardian, conservator, personal representative, estate, or survivors.

(b) The director may:

- (1) Compromise, or settle and release any such claim, or
- (2) Waive any such claim, in whole or in part, for the convenience

of the director, or if the director determines that collection would result in undue hardship upon the person who suffered the injury, or in a wrongful death action upon the heirs of the deceased.

(c) No action taken in behalf of the director pursuant to this section or any judgment rendered in such action shall be a bar to any action upon the claim or cause of action of the beneficiary, his guardian, conservator, personal representative, estate, dependents, or survivors against the third person who may be liable for the injury, or shall operate to deny to the beneficiary the recovery for that portion of any damages not covered hereunder.

(d) The cost of a service provided to an eligible developmentally disabled Medi-Cal beneficiary under Section 14132.44 may be recovered by the director from a liable third person or an insurance carrier.

14124.72. (a) Where an action is brought by the director pursuant to Section **14124.71**, it shall be commenced within the period prescribed in Section 338 of the **Code** of Civil Procedure.

(b) The death of the beneficiary does not abate any right of action established by Section **14124.71**.

(c) When an action or claim is brought by persons entitled to bring such actions or assert such claims against a third party who may be liable for causing the death of a beneficiary, any settlement, judgment or award obtained is subject to the director's right to recover from that party the reasonable value of the benefits provided to the beneficiary under the Medi-Cal program, as provided in subdivision (d).

(d) Where the action or claim is brought by the beneficiary alone and the beneficiary incurs a personal liability to pay attorney's fees and costs of litigation, the director's claim for reimbursement of the benefits provided to the beneficiary shall be limited to the reasonable value of benefits provided to the beneficiary under the Medi-Cal program less 25 percent which represents the director's reasonable share of attorney's fees paid by the beneficiary and that portion of the cost of litigation expenses determined by multiplying by the ratio of the full amount of the reasonable value of benefits so provided to the full amount of the judgment, award, or settlement.

14124.73. (a) If either the beneficiary or the director brings an action or claim against such third person or carrier the beneficiary or the director shall within 30 days of filing the action give to the other written notice by personal service or registered mail of the action or claim, and of the name of the court or state or local agency in which the action or claim is brought. Proof of such notice shall be filed in such action or claim. If an action or claim is brought by either the director or the beneficiary, the other may, at any time before trial on the facts, become a party to, or shall consolidate his action or claim with the other if brought independently.

(b) If an action or claim is brought by the director pursuant to subdivision (a) of Section **14124.71**, written notice to the beneficiary, guardian, conservator, personal representative, estate or survivor given pursuant to this section shall advise him of his right to intervene in the proceeding, his right to obtain a private attorney of his choice, and the director's right to recover the reasonable value of the benefits provided.

14124.74. In the event of judgment or award in a suit or claim against a third party or carrier:

(a) If the action or claim is prosecuted by the beneficiary alone, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees, when an attorney has been retained. After payment of these expenses and attorney's fees the court or agency shall, on the application of the director, allow as a first lien against the amount of the settlement, judgment, or award the reasonable value of additional benefits provided to the beneficiary under the Medi-Cal program, as provided in subdivision (d) of Section 14124.72, and as a second lien, the amount of any claims, pursuant to Section 14019.3, owed to a provider, as provided in Section 14124.791.

(b) If the action or claim is prosecuted both by the beneficiary and the director, the court or agency shall first order paid from any judgment or award, the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the beneficiary. After payment of these expenses and attorney's fees, the court or agency shall first apply out of the balance of the judgment or award an amount sufficient to reimburse the director the full amount of the reasonable value of benefits provided on behalf of the beneficiary under the Medi-Cal program, and then an amount sufficient to reimburse a provider who has filed a lien for any claims for services rendered to the beneficiary, as provided under Section 14124.791.

14124.75. The court or agency shall, upon further application at any time before the judgment or award is satisfied, allow as a further lien the reasonable value of additional benefits provided arising out of the same cause of action or claim provided on behalf of the beneficiary under the Medi-Cal Program, where such benefits were provided or became payable subsequent to the original order.

14124.76. No judgment, award, or settlement in any action or claim by a beneficiary to recover damages for injuries, where the director has an interest, shall be satisfied without first giving the director notice and a reasonable opportunity to perfect and satisfy his lien.

14124.77. When the director has perfected a lien upon a judgment or award in favor of a beneficiary against any third party for an injury for which the beneficiary has received benefits under the Medi-Cal Program, the director shall be entitled to a writ of execution as lien claimant to enforce payment of said lien against such third party with interest and other accruing costs as in the case of other executions. In the event the amount of such judgment or award so recovered has been paid to the beneficiary, the director shall be entitled to a writ of execution against such beneficiary to the extent of the director's lien, with interest and other accruing costs as in the case of other executions.

14124.78. Except as otherwise provided in this article, notwithstanding any other provision of law, the entire amount of any settlement of the injured beneficiary's action or claim, with or without suit, is subject to the director's claim for reimbursement of the reasonable value of benefits provided and any lien filed pursuant thereto, but in no event shall the director's claim exceed one-half of the beneficiary's recovery after deducting for attorney's fees, litigation costs, and medical expenses relating to the injury paid for by the beneficiary.

14124.79. In the event that the beneficiary, his guardian, conservator, personal representative, estate or survivors or any of them brings an action against the third person who may be liable for the injury, notice of institution of legal proceedings, notice of settlement and all other notices required by this code shall be given to the director in Sacramento except in cases where the director specifies that notice shall be given to the Attorney General. All such notices shall be given by insurance carriers, as described in Section 14124.70, having liability for the beneficiary's claim, and by the attorney retained to assert the beneficiary's claim, or by the injured party beneficiary, his guardian, conservator, personal representative, estate or survivors, if no attorney is retained.

14124.791. (a) Subject to the director's prior right of recovery, a provider who has rendered services to a beneficiary because of an injury for which a third party is liable and who has received payment under the Medi-Cal program shall be entitled to file a lien for all fees for services provided to the beneficiary against any judgment, award, or settlement obtained by the beneficiary or the director against that third party. A provider may only recover upon the lien if the provider has made a full reimbursement of any fees paid by the department for those services.

(b) If either the beneficiary or the director brings an action or claim against the third party, the party bringing the action shall, within 30 days of bringing the action, give written notice to any provider who is eligible to file a lien under subdivision (a) of the action and of the name of the court or state or local agency in which the action or claim is brought. Notice shall be given by personal service or registered mail, and proof of service shall be filed in the action or claim.

(c) The provider's claim for reimbursement for fees for services rendered to the beneficiary shall be limited to the amount of the fees less 25 percent, which represents the provider's reasonable share of attorneys' fees for prosecution of the action and of the cost of litigation expense.

(d) No claim authorized by this section shall be permitted to the extent that the claim would reduce the director's right to recover pursuant to Section 14124.78.

14124.795. It is the intent of the Legislature to comply with federal law requiring that when a beneficiary has other available health coverage or insurance, the Medi-Cal program shall be the payer of last resort. Notwithstanding any other provision of law, any carrier described in Section 14124.70, including automobile,

casualty, property, and malpractice insurers, shall enter into an agreement with the department to permit and assist the matching of the department's Medi-Cal eligibility file against the carrier's claim files, utilizing, if necessary, social security numbers as common identifiers for the purpose of determining whether Medi-Cal benefits were provided to a beneficiary because of an injury for which another person is liable, or for which a carrier is liable in accordance with the provisions of any policy of insurance. The carrier shall maintain a centralized file of claimants' names, mailing addresses, and social security numbers or dates of birth. This information shall be made available to the department upon the department's reasonable request. The agreement described in this section shall include financial arrangements for reimbursing carriers for necessary costs incurred in furnishing requested information.

14124.80. The Legislature finds and declares that:

(a) Many instances of potential third-party liability, particularly workers' compensation claims, are not discovered by the department. Similarly, the Legislature finds that there are private nongovernmental sources of potential claim information which is unique to these private sources and not otherwise readily available to the department. This private information is unique in that, although the information may be shared between private claimants, including potential private lienors, the department is not privy to it and includes past adjudicated claims, expired or expiring health policy claims, long-term care and settlement situations where Medi-Cal is not identified in any application or filing for benefits.

Additionally, there are applications and other filings made without any identification of potential Medi-Cal rights which become known to private sources because of this information sharing system. Further, there are other miscellaneous claims that have not been and will not be discovered in the ordinary course of administration by the department.

(b) There is a backlog of potential claims or liens which could result in the recovery of substantial amounts if private sources of information were available to the state.

(c) A cost-effective manner of recovering these potentially large amounts is through the contracting by the state, on a pilot program basis, with a private organization which possesses the expertise and resources required to rapidly discover and recover the lienable amounts owing by third parties for health care services provided by the Medi-Cal program, and which will receive compensation on a contingency fee arrangement, thereby supplementing the ongoing functions of the state in recovering lienable amounts, reducing the cost to the state of the recovery effort, and maximizing the amounts recovered for the Medi-Cal program.

(d) Attorneys or the beneficiary, his guardian, personal representative, estate or survivors of any of them who are currently mandated under Section 14124.79 to report Medi-Cal involvement are excluded from any further remuneration benefits under this section.

14124.81. The State Department of Health Services shall administer the provisions of Sections 14124.82 to 14124.88, inclusive. The department shall establish a pilot project for the discovery and recovery of amounts owing by third parties for health care services provided by the Medi-Cal program.

14124.82. (a) The department shall enter, by October 1, 1981, into at least two at-risk performance type contracts with private organizations that have access to information on cases with potential for the recovery of amounts owing for services rendered under the Medi-Cal program, and that have access to a substantial backlog period of information on past due Medi-Cal claims, as well as current and future potential claims. At least one contract shall cover northern California claims, and at least one contract shall cover southern California claims. Any contractor, otherwise qualified under this section, may separately contract in each geographical area.

(b) Priority, by the terms of the contract or contracts, shall be given to the identification and recovery of claims nearing the statute of limitations, prior adjudicated claims, and prior existing injury claims. However, all claims which are older, in whole or part, than 12 months, at the time of discovery and notification by the contractor to the department, shall be subject to contractual lien recovery unless departmental personnel have previously identified these claims and have filed appropriate liens, notices, or other payment demands. A claim arises and the 12-month period begins when the department or its fiscal agent has first made payment for medical services related to the personal or workers' compensation action on behalf of a given recipient. The department may waive any time requirement, if it concludes that it will not otherwise discover the claim and be able to effect recovery.

14124.83. The agreement shall include, but is not limited to, the following provisions:

(a) The contractor shall discover and recover amounts owing by third parties which may be subject to a claim for reimbursement.

(b) Payment to the contractor shall be based upon a no cost percentage of recovery formula, which shall not exceed 25 percent of the gross recovery upon the claim. It is the intent of the Legislature that "no cost" include all considerations for court costs, legal fees, and the universe of the case processing activity, not including, however, departmental processing.

(c) The contractor shall report periodically to the department concerning its progress in the discovery of cases and the recovery of amounts subject to claim, and shall provide such other information as the department may require to adequately monitor the progress of the contractor. Reports and other information shall be required only at one-month intervals.

14124.84. The department shall provide the contractor with such information as is reasonably necessary for the contractor to perform its obligations under the contract, including accounting data and other information the contractor may request.

14124.85. The contractor, for the duration of the contract period, shall have the powers of the Director of the State Department of

Health Services as set forth in this article, except for the power to waive a claim under paragraph (2) of subdivision (b) of Section 14124.71. The contract shall specify the particular means and documentation of the delegation of powers under paragraph (1) of subdivision (b) of Section 14124.71. The contractor shall be subject to the provisions of Section 14100.2 except that those provisions shall not inhibit performance of the contract.

14124.86. The pilot project contract entered into by the department pursuant to Section 14124.82 shall not exceed a term of three years from the date of its execution. The contractor shall retain its rights and duties under the contract with respect to any claims or liens processed in whole or in part prior to the termination date of the agreement.

14124.88. (a) Subsequent to the expiration of the pilot project contract, the department, in its reasonable discretion, may execute a separate, additional agreement for the discovery and recovery of amounts which may be subject to claim pursuant to this article, subject to Sections 14124.81 to 14124.87, inclusive.

(b) The department, if it receives a competitive qualified offer of such services within the criteria set forth in Sections 14124.80 through 14124.87, shall separately contract for discovery and recovery of workers' compensation claims with one contract to cover areas of northern California and one to cover areas of southern California.

(c) (1) Priority and inclusion of claims shall be as set forth in subdivision (b) of Section 14124.82 and additionally shall include any matter on file with the Workers' Compensation Appeals Board for a period of more than 12 months unless the department has previously identified these claims and has filed the appropriate lien or liens.

(2) The contract may include, or may be subsequently amended to include, any or all previously identified claims and any other potential lien claims, identified or not, if the department determines that it will not otherwise be able to effectively process recovery. This paragraph shall cease to be operative on January 1, 1995.

(d) There shall be no cost to the contractor for claim detail reports provided by the fiscal intermediary. In all cases of workers' compensation appeals, payment shall be made directly to the state and a contractor shall not handle or have access to any moneys owing the state. In these cases a bond required by the state for collection agencies shall be sufficient. Contractor's files shall be subject to audit, pursuant to the contract, but shall remain the property of the contractor. At the request of the department, the contractor shall provide copies of any claims related to a particular recovery.

X (e) The contract shall provide that the contractor, with the permission of the Attorney General, may appeal decisions of the Workers' Compensation Appeals Board.

14124.89. (a) Every health care service plan, self-insured employee welfare benefit plan, disability insurer, and nonprofit hospital

service plan shall, upon request of the department for any records, or any information contained in records pertaining to an individual or group health insurance policy or plan issued by such insurer or plan against, or pertaining to the medical or dental benefits paid by or claims made against such insurer or plans under a policy or plan, make the requested records or information available upon a certification by the department that the individual is an applicant for or recipient of services under this chapter or is a person who is legally responsible for such an applicant or recipient.

(b) The department shall enter into a cooperative agreement setting forth mutually agreeable procedures for requesting and furnishing appropriate information, not inconsistent with any law pertaining to the confidentiality and privacy of medical records, which procedure shall include such financial arrangements as may be necessary to reimburse insurers or plans for necessary costs incurred in furnishing requested information, and the time and manner such procedures are to become effective. Reimbursement to insurers or plans complying with the provisions of this section shall be at the same rate of reimbursement used to reimburse the Department of Motor Vehicles for providing information to insurance carriers.

(c) The information required to be made available pursuant to this section shall be limited to information necessary to determine whether health benefits have been or should have been claimed and paid pursuant to a health insurance policy or plan with respect to items of medical care and services received by a particular individual for which Medi-Cal coverage would otherwise be available.

(d) Not later than the date upon which the procedures agreed to pursuant to subdivision (b) become effective, the director shall establish guidelines to assure that information relating to an individual certified to be an applicant for or recipient of medical assistance, furnished to any insurer or plan pursuant to this section, is used only for the purpose of identifying the records or information requested in such manner so as not to violate the confidentiality of an applicant or recipient.

(e) The department shall implement the provisions of this section by January 1, 1983.

14124.90. It is the intent of the Legislature to comply with federal law requiring that when a beneficiary has third-party health coverage or insurance, the State Department of Health Services shall be the payer of last resort. In order to assess overlapping or duplicate health coverage, every health care service plan, self-insured employee welfare benefit plan, including those regulated pursuant to the Employee Retirement Income Security Act of 1974 (Public Law 93-406), self-funded employer plan, disability insurer, nonprofit hospital service plan, labor union trust fund, employer, and any other similar plan, insurer, or entity shall maintain a centralized file of the subscribers', policyholders', or enrollees' names, mailing addresses, and social security numbers or date of birth, and where available, for all other covered persons, the names and social security numbers or date of birth. This information shall be made available to the State Department of Health Services upon reasonable request. Notwithstanding Section 20134 of the Government Code, the Board of Administration of the California Public Employees' Retirement System and affiliated systems or contract agencies shall permit data matches with the state department to identify Medi-Cal beneficiaries with third-party health coverage or insurance. A

recipient's Medi-Cal identification card shall, where information is available, contain information advising providers of health care services of any third-party health coverage for the recipient. Providers shall seek reimbursement from available third-party health coverage before billing the Medi-Cal program.

14124.91. The State Department of Health Services shall, whenever it is cost-effective, pay the premium for third-party health coverage for beneficiaries under this chapter. The State Department of Health Services shall, when a beneficiary's third-party health coverage would lapse due to loss of employment or change in health status, lack of sufficient income or financial resources, or any other reason, continue the health coverage by paying the costs of continuation of group coverage pursuant to federal law or converting from a group to an individual plan, whenever it is cost-effective. Notwithstanding any other provision of a contract or of law, the time period for the department to exercise either of these options shall be 60 days from the date of lapse of the policy.

14124.92. (a) The department may pay administrative expenses and make incentive payments to any county, state, or federal agency, or a contracting agent of the department for identifying and reporting third-party health care coverage held or offered to beneficiaries under this chapter.

(b) Unless the third-party health care coverage identified is excluded under subdivision (d) from the incentive payment plan, an agency or contractor may be entitled to an incentive payment if the agency or contractor does all of the following:

(1) Identifies a case of which the department was not previously aware.

(2) Provides to the department adequate and necessary information relevant to the third-party health care coverage in order to make a claim for benefits or reimbursement for services rendered that would otherwise be paid by Medi-Cal.

(3) Reports to the department the identified third-party health care coverage within 30 days of the date of discovery on a form approved by the department.

(c) In no event shall any one incentive for each case identified exceed one month of savings received by the department for benefits paid by the third-party health care coverage.

(d) Third-party health care coverage that does not qualify for the incentive payment plan under this section shall be identified by the department based on policy limitations and cost-effectiveness. The types of coverage that do not qualify under this section include those that to which any of the following apply:

(1) Not specifically intended to provide third-party health care coverage, such as coverage that provides life or car insurance benefits, periodic benefits for disability or hospitalization, or income protection.

(2) Coverage is limited to a specific diagnosis, unless the beneficiary has been diagnosed with a condition or disease specified in the coverage.

(3) Coverage is limited to a specific circumstance, such as accidental injury or dismemberment.

(4) Coverage is limited to one specific category of service.

(e) For the purposes of this section, "third-party health care

coverage" means health care service plans, benefits, insurance policies, and funds, including those described in Section 14124.90.

14124.93. (a) The Department of Child Support Services shall provide payments to the local child support agency of fifty dollars (\$50) per case for obtaining third-party health coverage or insurance of beneficiaries, to the extent that funds are appropriated in the annual Budget Act.

(b) A county shall be eligible for a payment if the county obtains third-party health coverage or insurance for applicants or recipients of Title IV-D services not previously covered, or for whom coverage has lapsed, and the county provides all required information on a form approved by both the Department of Child Support Services and the State Department of Health Services.

(c) Payments to the local child support agency under this section shall be suspended for the 2003-04, 2004 -05, 2005-06, and 2006-07 fiscal years.

14124.94. (a) When the rights of a Medi-Cal beneficiary to health care benefits from an insurer have been assigned to the department, an insurer shall not impose any requirement on the department that is different from any requirement applicable to an agent or any assignee of the covered beneficiary.

(b) The department, in the administration of the Medi-Cal program, may garnish the wages, salary, or other employment income of, and withhold amounts from state tax refunds from, any person to whom both of the following apply:

(1) The person is required by a court or administrative order to provide coverage of the costs of health services to a child who is eligible for medical assistance under the Medi-Cal program.

(2) The person has received payment from a third party for the costs of the health services for the child, but he or she has not used the payments to reimburse, as appropriate, either the other parent or the person having custody of the child, or the provider of the health services, to the extent necessary to reimburse the department for expenditures for those costs under the Medi-Cal program. All claims for current or past due child support shall take priority over claims made by the department for the costs of Medi-Cal services.

(c) For purposes of this section, "insurer" includes every health care service plan, self-insured welfare benefit plan, including those regulated pursuant to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001, et. seq.), self-funded employer plan, disability insurer, nonprofit hospital service plan, labor union trust fund, employer, and any other similar plan, insurer, or entity offering a health coverage plan.